

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11496

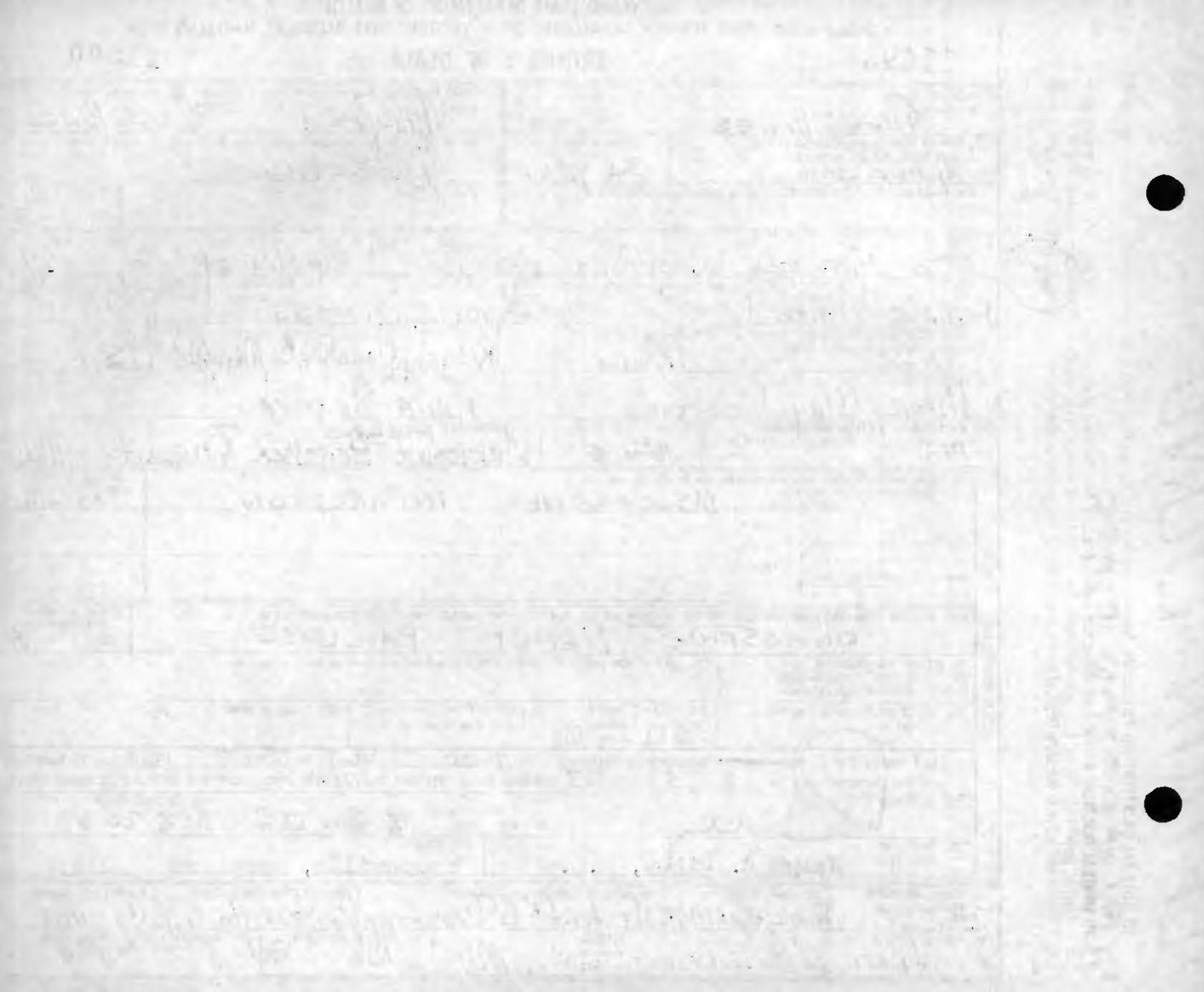
CERTIFICATE OF DEATH

11500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event of an accident, page 4 may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY <i>QUEEN ANNE'S</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>QUEENSTOWN</i>		c. LENGTH OF STAY IN lb <i>35 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>QUEENSTOWN</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>FRANCES Woolford Beecher</i>		4. DATE OF DEATH <i>August 18, 1967</i>	Month Day Year 19 67
S. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>April 13, 1912</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years last birthday) yrs. <i>55</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Ridgely, Caroline Co., Maryland U.S.A.</i>
13. FATHER'S NAME <i>Henry Clay Woolford</i>	14. MOTHER'S MAIDEN NAME <i>Anna Greaves</i>	12. CITIZEN OF WHAT COUNTRY <i>Maryland U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>Husband</i>	Address <i>Virbrook Beecher Queenstown Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>MYOCARDIAL INFARCTION</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>CONGESTIVE HEART FAILURE</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>Aug. 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>(City or town) (County) (State)</i>
21. I certify that (I) <i>this hospital</i> attended the deceased from <i>7-20</i> , 19 <i>67</i> , to <i>8-18</i> , 19 <i>67</i> , that (I) <i>saw the deceased alive on 8-13, 1967</i> , and that death occurred at <i>5:35 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>8-20-67</i>	
22a. SIGNATURE <i>D. Libby</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS <i>Grasonville, Maryland 21638</i>
22c. PHYSICIAN'S NAME (Type) <i>Ralph E. Libby, M.D.</i>		23d. LOCATION (City or Town) (County) (State) <i>Chesterville, Md. Calvert Co. Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>August 21, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Chesterville Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Chesterville, Md. Calvert Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Jesse H. Barton Jr. - Barton Bros. Chesterville, Md.</i>		25a. ADDRESS <i>Jesse H. Barton Jr. - Barton Bros. Chesterville, Md.</i>	
25b. REG'D BY REGISTRAR <i>Jesse H. Barton Jr. - Barton Bros. Chesterville, Md.</i>		25c. REGISTRAR'S SIGNATURE <i>Jesse H. Barton Jr. - Barton Bros. Chesterville, Md.</i>	



**FOR STATE
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 392 MARYLAND STATE DEPARTMENT OF HEALTH
9-15-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #1b & d & 2c & d Film #G392 9/6/67 ph

11501

1149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.		b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Centreville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester		d. STREET ADDRESS RFD		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) private residence				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Cannon		First	Middle	Lost	4. DATE OF DEATH 5	Month	Doy	Year
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-22-1918	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Archie Cadlett		14. MOTHER'S MAIDEN NAME Victoria Harris						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 237-22-0088		17. INFORMANT Lillie Terrell		Address Raleigh, N. Carolina		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH ?				
(b)		DUE TO Generalized arteriosclerosis with narrowing of coronary arteries				Years		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>C.R. Layton M.D.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		1/30/67		
EXAMINER'S NAME (Type) C.R. Layton, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-67		23c. NAME OF CEMETERY OR CREMATORIUM TALLY-ho CEMETERY		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR G.H. Dashiell		ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE AUG 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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1

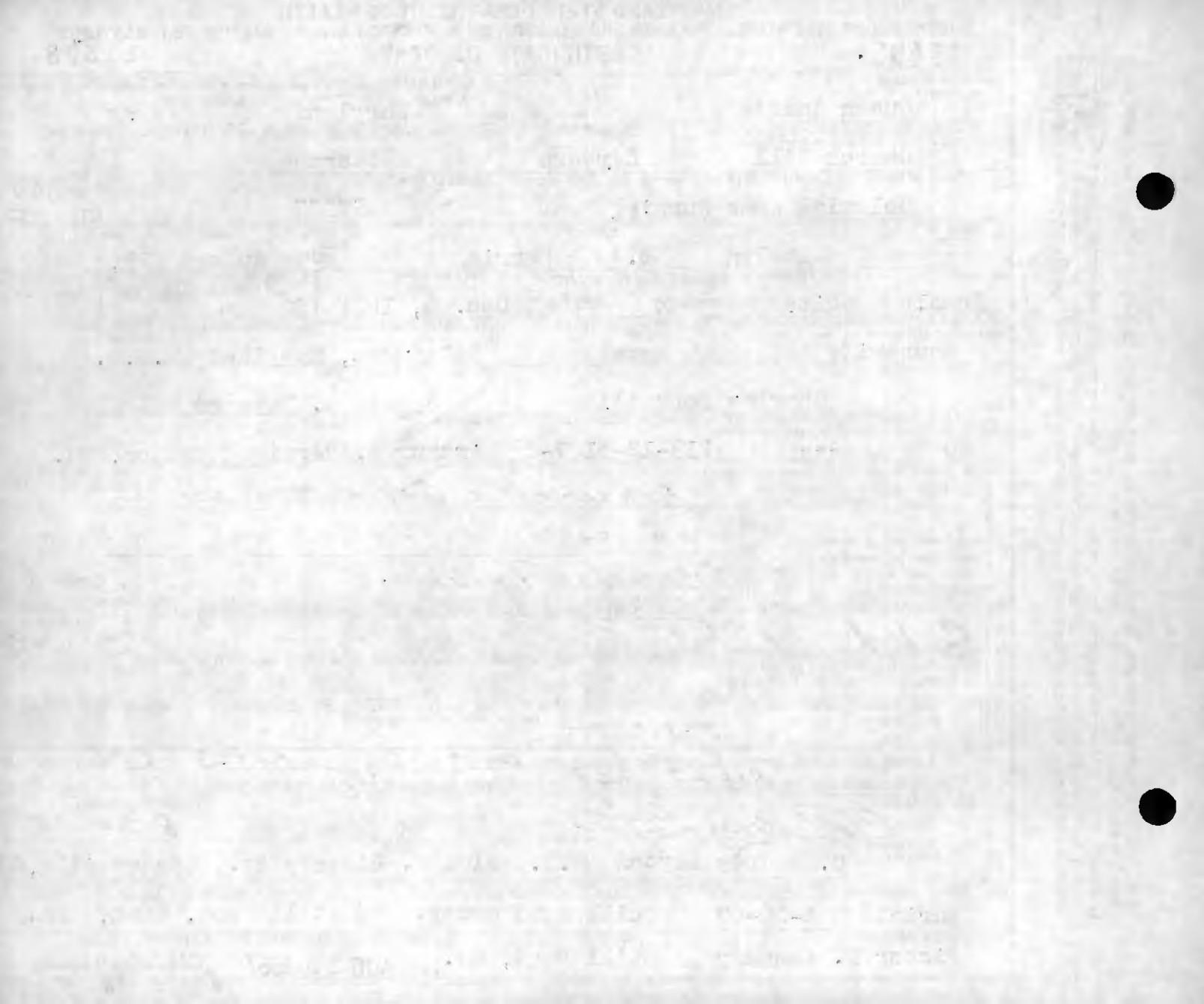
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11498

CERTIFICATE OF DEATH

11503

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton d. STREET ADDRESS -----		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Arms Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Evelyn	Middle B.	Last Harris	
4. DATE OF DEATH	Month August	Day 23,	Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1884 9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Bockmiller		14. MOTHER'S MAIDEN NAME Jessie H. Baynard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-5187-T 17. INFORMANT Arthur L. Harris Address Worton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio Vascular disease</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>disease</i> <i>year</i> (c) <i>Bronchitis Pneumonia</i> <i>1 week</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>C.V.A 1965</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, street, office bldg., etc.	20f. (City or town) Arthur L. Harris (County) Worton (State) Md.
21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1967 to Aug 23, 1967 , that (I) (we) last saw the deceased alive on Aug 23, 1967 , and that death occurred at Still Pond, Md. from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <i>Rodney Layton</i>		22b. DATE SIGNED P-24-C7		
22c. PHYSICIAN'S NAME (Type) C. Rodney Layton M.D.		22d. ADDRESS 104 S. Liberty Av., Centreville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-26-67	23c. NAME OF CEMETERY OR CREMATORIAL Still Pond Cemetery	23d. LOCATION (City, town or county) Still Pond, Kent, Md. (State)
24. FUNERAL DIRECTOR Victor N. Kennedy		ADDRESS Still Pond, Md.		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DATE AUG 25 1967
VR A15 (4) 15M 4-64				



Item 18 Film 392 8-24-67 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

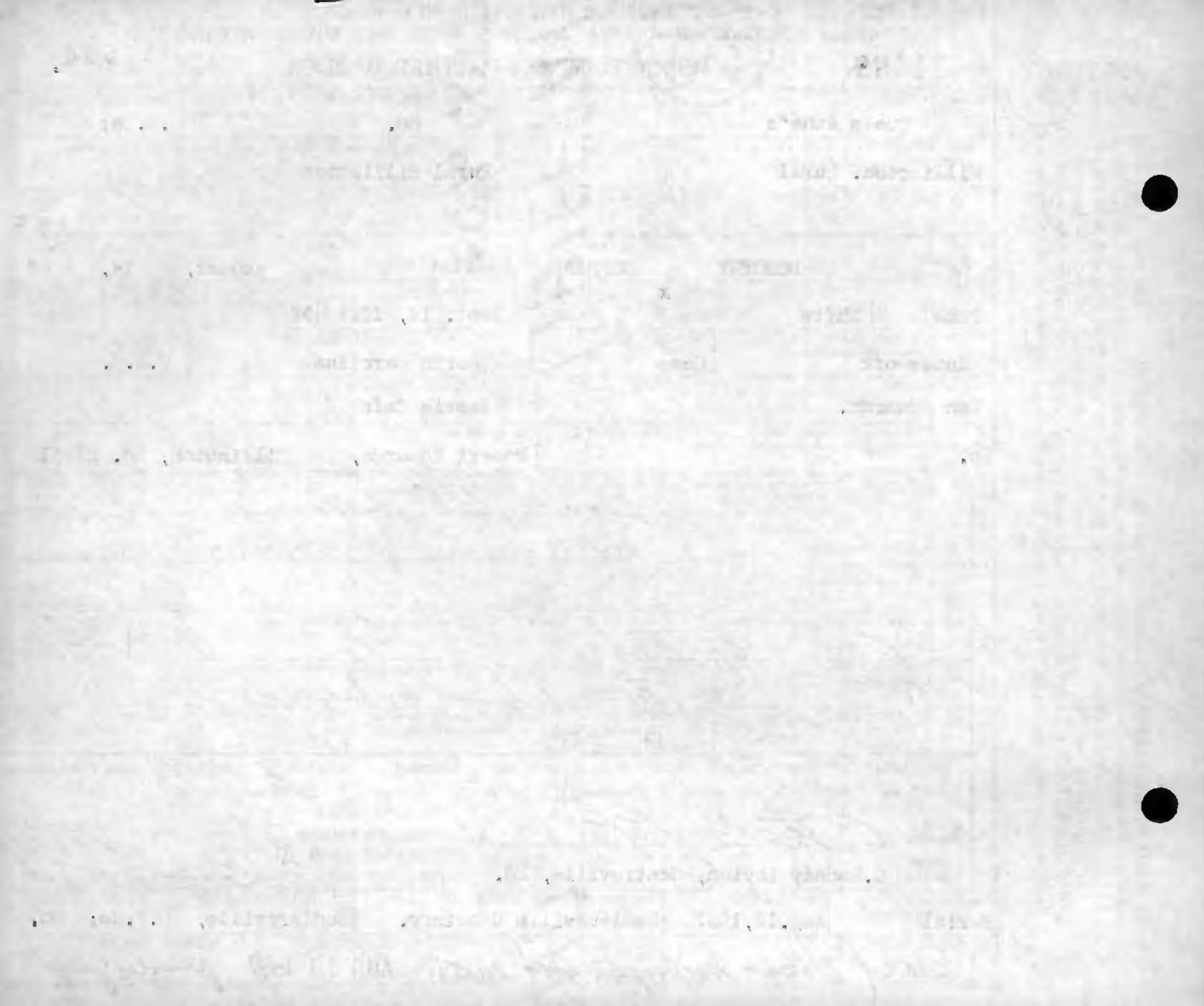
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11499

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11504

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Q.A.Co;					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington, Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington 17-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First DOROTHY	Middle SOPHIA	Last JOHNSON	4. DATE OF DEATH August, 14, 1967	Month	Year		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 14, 1928	9. AGE (In years 38 last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dan Edwards.				14. MOTHER'S MAIDEN NAME Bessie Cain					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No.		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Edwards, Address Millington, Md. 21651					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 880.9 DUE TO <i>Acute Alcoholism</i> INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Alcohol poisoning Bl alcohol .43</i> (c) DUE TO <i>Unknown</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Known Epileptic									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Brought home by friends</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>C. Rodney Layton</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Centreville, Md.						22. DATE SIGNED 9-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 18, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Sudlersville Cemetery.		23d. LOCATION (City or Town) (County) (State) Sudlersville, Q.A.Co; Md.			
24. FUNERAL DIRECTOR Edward Wilson Millington Md. 21651		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15ME 6M 1/68				DATE AUG 21 1967					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

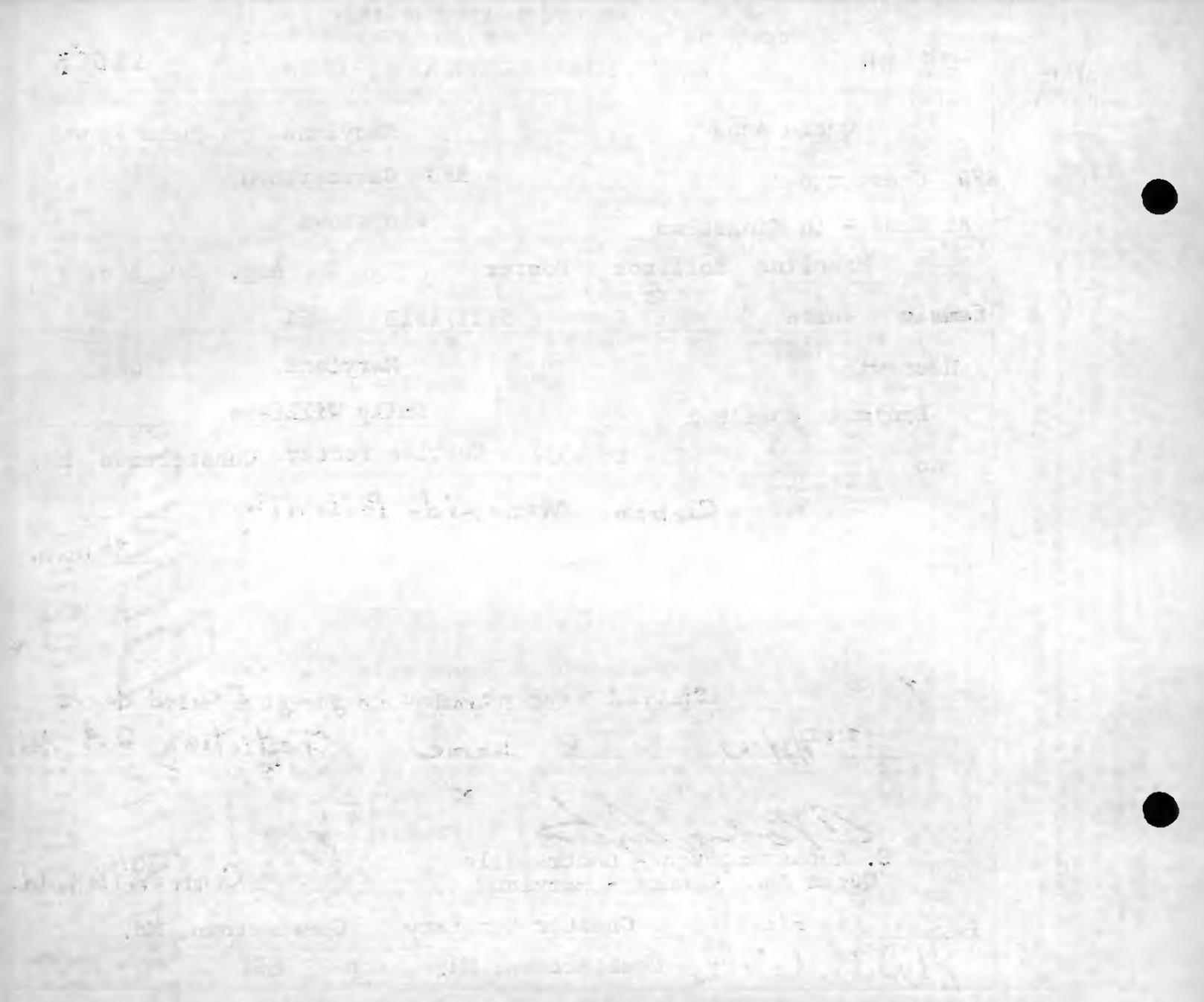
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

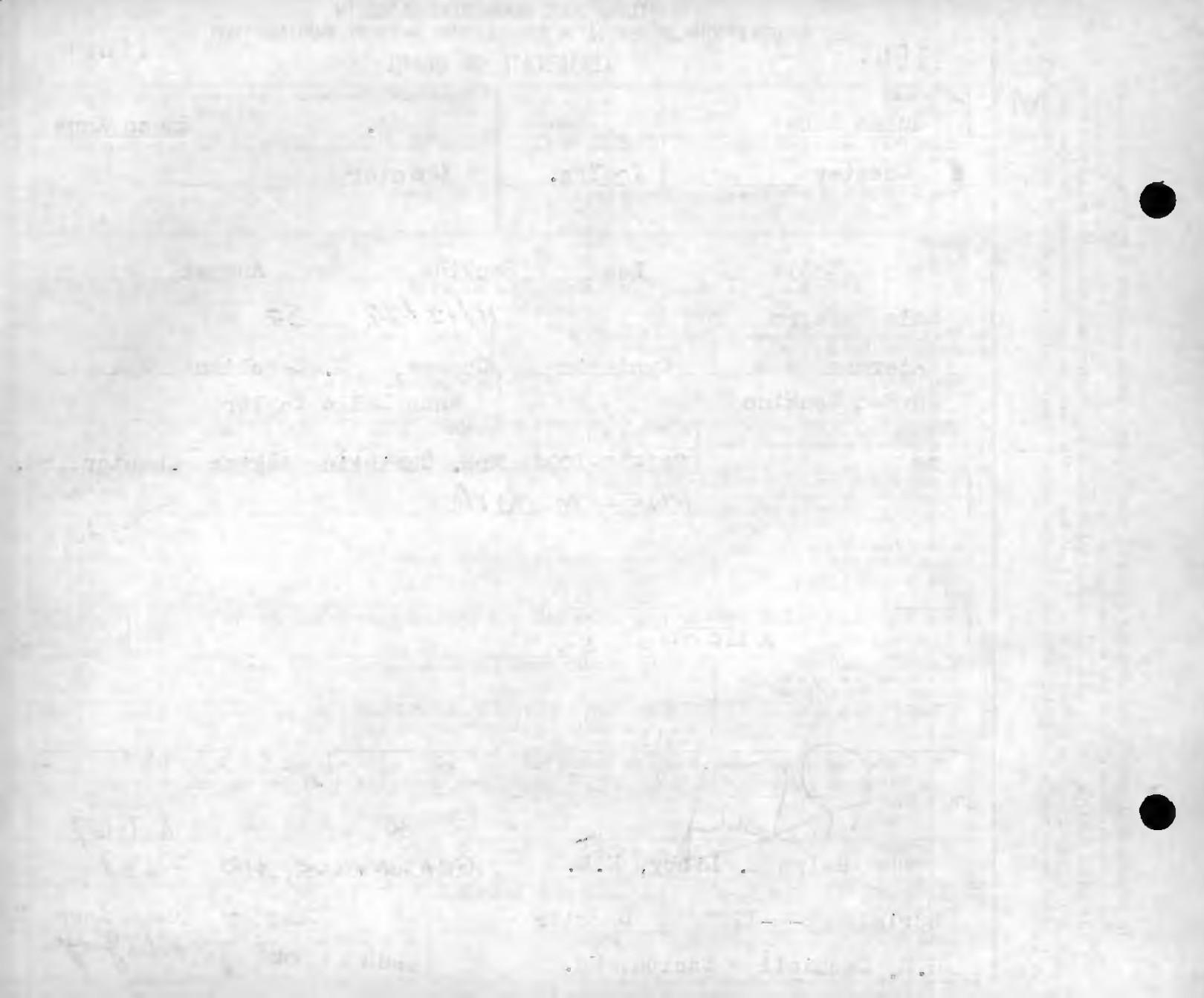
11500		11505	
1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Chestertown		c. LENGTH OF STAY IN 1b 17.1	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) At Home - in Kingstown		d. STREET ADDRESS Kingstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) First Middle Last Madeline Rollison Porter		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) female		4. DATE OF DEATH Aug. 30, 1967 19	
5. SEX white		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/21/1913		9. AGE (In years lost birthday) yrs. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Rollison		14. MOTHER'S MAIDEN NAME Emily Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 18 4537	
17. INFORMANT Charles Porter		Address RFD Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO 9731 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Started 3 engine motors in garage & closed doors	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 3:45 p.m. 8/30/1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. CITY OR TOWN (County) (State) Chestertown 2.A Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE C. Rodney Layton		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) C. Rodney Layton Centreville Queen Anne County - Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 8/30/67		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/1/67	
23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION (City or Town) (County) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE SEP 5 1967			



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11506				
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Queen Anne					MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester					c. LENGTH OF STAY IN lb 10 Yrs.					b. COUNTY Queen Anne				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS Chester					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Eddie	Middle Lee	Last Renkins	4. DATE OF DEATH August 2 1967			Month August	Day 2	Year 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/12/27	C. AGE (In years last birthday) 39 yrs.	D. IF UNDER 1 YEAR Months Days	E. IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman			10b. KIND OF BUSINESS OR INDUSTRY Oystering			11. BIRTHPLACE (County & State, or foreign country) Chowan, N. Carolina			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Jordan Renkins			14. MOTHER'S MAIDEN NAME Anna Belle Taylor			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 244-T0-T094			17. INFORMANT Mrs. Christine Askins Chester, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 473X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)			PNEUMONIA									INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ALCOHOLISM												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 7-30, 1967, to 8-2, 1967, that (I) (we) last saw the deceased alive on 7-30 1967, and that death occurred at 5:30 AM, from causes and on the date stated above.														
22a. SIGNATURE Ralph E. Libby						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 8-7-67		
22c. PHYSICIAN'S NAME (Type) Ralph E. Libby, M.D.			22d. ADDRESS GRASONVILLE MD. 21638			23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 8-6-1967			23c. NAME OF CEMETERY OR CREMATORIAL Chester		
24. FUNERAL DIRECTOR G.H. Dashiell			ADDRESS Easton, Md.			25a. RECD. BY REGISTRAR DATE AUG 11 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					



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To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-RD-1. JO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

11502

11507

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne's</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>	c. LENGTH OF STAY IN lb <i>most of life</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS <i>Rural Route #1</i>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	17-1		
3. NAME OF DECEASED (Type or print) <i>JAMES OSCAR SPARKS</i>	First Middle Last	4. DATE OF DEATH <i>August 14, 1967</i>	Month Day Year
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>Sept. 8, 1893</i>
8. AGE (In years last birthday) <i>73 yrs.</i>	9. IF UNDER 1 YEAR Months Days Hours Min.	10. KIND OF BUSINESS OR INDUSTRY <i>Farm owner</i>	11. BIRTHPLACE (State or foreign country) <i>Centreville, Q.A.C., Md.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13. FATHER'S NAME <i>WALTER SIMPLER SPARKS</i>	14. MOTHER'S MAIDEN NAME <i>Minnie McClyment</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-36-0756</i>	17. INFORMANT <i>Son</i>	Address <i>Willard M. Sparks, Centreville, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <i>Hyper tension, cardiovascular</i> } DUE TO (c) <i>disease</i> } DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>C. P. Layton</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>C. P. Layton</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>August 16, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Chesterfield Cemetery</i>	23d. LOCATION (City or town) (County) (State) <i>Centreville, Q.A.C., Md.</i>
23f. FUNERAL DIRECTOR <i>John H. Baileys, Baileys, Centreville, Md.</i>	ADDRESS <i>100 Main Street, Centreville, Md.</i>	23g. RECD BY REGISTRAR DAUG 17 1967	23h. REC'D BY CLERK <i>John H. Baileys</i>

